

CHAPTER VI: HOME HEALTH PPS PAYMENT CALCULATIONS	3
OBJECTIVES	3
BACKGROUND	4
CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNT	5
ADJUSTMENTS TO STANDARDIZED PROSPECTIVE PAYMENT RATE.....	6
Sample Payment Computation Data.....	6
Case-Mix Adjustment	7
Wage Index Adjustment.....	7
REQUEST FOR ANTICIPATED PAYMENT.....	8
FINAL PAYMENT ADJUSTMENTS	9
Low-Utilization Payment Adjustments	9
Partial Episode Payments	11
Adjustment for Significant Change in Condition.....	14
Claims Examples	17
Sample Claim #1 -Processed RAP	18
Sample Claim #2 -Processed Final Claim (LUPA)	19
Sample Claims # 3 -Processed Final Claim	20
Sample Claim # 4 -Processed Final Claim (PEP Adjustment)	21
Sample Claim #5 - Processed Final Claim (SCIC Adjustment).....	22
OUTLIER ADJUSTMENTS	23
Sample Outlier Computation (Note: All Calculations are Performed Automatically by the HHPPS Pricer Program).....	25
Step 2 - Calculate Outlier Threshold Amount.....	26
Step 3 - Calculate Outlier Payment.....	27
Total Payment to Provider (Episode plus Outlier Payment).....	27
HH PPS PRICER DESIGN (AS OF 5/16/00).....	28
Input Data File.....	28
PROVIDER SPECIFIC FILE.....	30
HH PPS REMITTANCE ADVICE INSTRUCTIONS.....	31
COST REPORT IMPACT	37
Other HHA SERVICES	38
Payment under Outpatient Prospective Payment System (OPPS) for Certain Services Provided by HHAs	38
Category	38
Payment Under the Prospective Payment System for Outpatient Rehabilitation Services	38
PS&R Reports	39
New PS&R Reports.....	39

CHAPTER VI: HOME HEALTH PPS PAYMENT CALCULATIONS

OBJECTIVES

The objective of this chapter is to provide participants with an understanding of the Home Health Prospective Payment system payment provisions. At the end of this session, participants will obtain an understanding of:

- The computation of the base 60-day episode payments for the 80 home health resource groups as represented by 640 HIPPS codes.
- The computation of adjustments to the 60-day episode payment for low utilization or outlier situations.
- The prorating of payments for significant changes in the patient condition, beneficiary elected transfers or discharge and readmission to the same HHA.
- The effect of HH PPS on the PS&R and cost reporting.

BACKGROUND

Episode of Care Payment

- **60-day Period**
- **Adjusted for Health Condition and Care Needs**
- **Adjusted for Wage Variances**
- **No Limit to Number of Episodes**

Payment for services under the home health PPS system is calculated based on a predetermined base payment. The base payment will be adjusted for the health condition and care needs of the beneficiary (case-mix adjustment). Payments will also be adjusted to reflect the geographic differences in wages for HHAs across the country (wage index adjustment).

HH PPS will provide HHAs with payments for each 60-day episode of care for each beneficiary serviced by the HHA. If a beneficiary is still eligible for care after the end of an episode, a second episode can begin. There are no limits to the number of episodes an eligible beneficiary can receive.

Split Payment Approach

- **Initial Episode 60/40 Split**
- **Subsequent Episodes 50/50 Split**

The unit of payment under HH PPS is a 60-day episode of care. HHAs will receive 60 percent of the estimated base payment for the first full 60-day episode as soon as the fiscal intermediary receives the initial claim. The estimated payment will be based on the patient's condition and care needs. The agency will receive the remaining 40 percent of the payment at the close of the 60-day episode unless there is an applicable adjustment to that amount. All subsequent episodes will be paid at a 50/50-split percentage payment.

The split percentage payment approach was developed to provide reasonable and balanced cash flow to participating HHAs.

Payment calculations are performed by the HH PPS Pricer software driver, which interacts with existing standard system software (FISS and APASS). Pricer computes calculations to the ninth decimal place. However, most of the examples in this chapter are rounded to two decimal places for easy comprehension.

CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNT

Calculation of National 60-Day Episode Amount

- **FY 1997 Cost Report Data Used to Compute Mean Cost per-Visits**
- **97 and 98 Claims Data used to Compute Mean Utilization Amounts**
- **Updated For Inflation**

Resulted in Non-Standardized Prospective Payment Amount

HCFA used audited cost report data for cost reports that ended in fiscal year 1997, to compute national mean cost per visits, for each of the six disciplines (skilled nursing, physical therapy, occupational therapy, speech-language pathology services, medical social services, and home health aide services).

The national mean cost per visit amounts were then multiplied by the national mean utilization for each of the six disciplines in a 60-day episode to arrive at a national cost per episode amount. The national mean utilization amounts were derived utilizing data from the 1997 and 1998 National Claims History File.

The cost per episode amount was updated for inflation and additional amounts were added for the following:

- Non-routine medical supplies paid on a reasonable-cost basis under a home health plan of care
- Non-routine medical supplies that could have been unbundled to Part B that will be included under the PPS rate
- Therapy services that could have been unbundled to Part B that will be included under the PPS rate
- An OASIS adjustment to pay HHAs for estimated ongoing OASIS assessment reporting costs
- A one-time implementation adjustment to pay HHAs for estimated costs associated with implementing revisions to the OASIS

**Non-Standardized
Prospective Payment
Amount Adjusted for:**

- Case-mix
- Budget Neutrality
- Outlier

**2001 Standard
Prospective Payment
Rate \$2,115.30**

The resulting nonstandardized average prospective payment amount was further adjusted for the following:

- Standardized for case-mix and wage index
- Adjusted for budget-neutrality
- Divided by 1.05 to provide for outlier payments

The final standardized and budget neutral prospective payment amount per 60-day episode for FY 2001 is \$2,115.30.

**ADJUSTMENTS TO STANDARDIZED
PROSPECTIVE PAYMENT RATE****Sample Payment Computation Data**

To assist in understanding the payment concepts of the HH PPS system, we will work through the computations for an HHA with the following information:

- Services provided to beneficiary in State College, PA.
- OASIS has determined that the beneficiary is in HHRG C2F2S0 (HIPPS code HCGJ1)
- The Standardized Prospective Payment Rate for FY 2001 has been defined as \$2,115.30.
- The beneficiary receives the first billable service on October 1, 2000.

Case-mix Adjustment**Listing of HHRG, HIPPS,
and Weights****Case-Mix Adjustment**

A listing of the 80 HHRG Groupings and the appropriate case-mix weight has been published in the final rule (table 9). A listing of the HHRGs, HIPPS codes and case-mix weights is also included in the appendix (section 1) of this manual.

In our example, OASIS has determined that the beneficiary is in HHRG C2F2S0. Using the listing included in section 1 of the appendix, we can identify a HIPPS code of HCGJ1 and a case mix weight of 0.9949. The case-mix adjusted prospective rate would be computed as follows:

Computation of Case-Mix Adjusted Prospective Payment Amount		
1	Weight for HCGJ1	0.9949
2	Standardized Prospective Payment Rate	\$2,115.30
3	Calculated case-mix adjusted prospective payment rate (line 1 x line 2)	\$ 2,104.51

Wage Index

- **Hospital Wage index**
- **Pre-Reclassification**
- **Pre-Floor**
- **Labor Portion**
77.668%

Wage Index Adjustment

Under HH PPS, the labor portion of the 60-day episode payment will be adjusted by the appropriate wage index for the geographic area in which the beneficiary received home health services. The hospital wage index in effect for the federal fiscal year will be used to determine payments for home health services. The wage index values, pre-floor and pre-reclassification, will be published in the *Federal Register*.

Based on an analysis of the components of the HH market basket, HCFA has determined that 77.668% of the standardized prospective payment rate represents labor costs.

Services for our example were provided to a beneficiary located in State College, PA. State

College is located in MSA 8050, with a wage index of .9139.

The case-mix adjusted prospective rate will be adjusted for the wage index as follows:

Wage Index Adjustment to Case-Mix Adjusted Prospective Payment Amount		
1	Case Mix Adjusted Prospective Payment Rate (from above)	\$ 2,104.51
2	Labor Percentage of Prospective Payment Rate	0.77668
3	Labor Portion of Prospective Payment Rate (line 1 x line 2)	\$ 1,634.53
4	Wage Index Factor	.9139
5	Wage Adjusted Labor Portion of Prospective Payment Rate (line 3 x line 4)	\$ 1,493.80
6	Non-Labor Portion of Prospective Payment Rate (line 1 less line 3)	\$ 469.98
7	Total Adjusted Prospective Payment Rate (line 5 + line 6)	\$ 1,963.78

REQUEST FOR ANTICIPATED PAYMENT

RAP

- **Initial Episode 60/40 Split**
- **Subsequent Episodes 50/50 Split**

HHAs will receive 60 percent of the estimated base payment for the first full 60-day episode as soon as the fiscal intermediary receives the request for anticipated payment (RAP). All subsequent RAPs for the beneficiary will be paid at 50%. The agency will receive the remaining 40 percent (or 50 percent) of the payment at the close of the 60-day episode unless there is an applicable adjustment to that amount. Note: RAPs are not equivalent to claims in terms of Medicare stature and therefore are not subject to either the payment floor or interest payments (in cases where a clean RAP is held up in claims processing).

Using our example (see sample claim #I in this chapter), following is a calculation of the RAP and a calculation of the additional final payment for the episode. For this calculation, it is assumed that the final payment will not be subject to any payment

adjustments that will be discussed later in this chapter.

Calculation of Initial (RAP) and Final Prospective Payment Amount		
1	Total Adjusted Prospective Payment Rate (from above)	\$ 1,963.78
2	Initial (RAP) Percentage	60%
3	Initial (RAP) Payment (line 1 x line 2)	\$ 1,178.27
4	Final HH PPS Payment (Line 1 – Line 3)	\$ 785.51

FINAL PAYMENT ADJUSTMENTS

Low-Utilization Payment Adjustments

Low Utilization Payments

- **Four of Fewer Visits**
- **Per-Visit Methodology**

The final regulations provide for payments for low-utilization episodes under HH PPS. Low-utilization episodes have been defined as those with 4 or fewer home health visits in the 60-day episode. Low utilization adjustments (LUPAs) would reduce the HH PPS payment for services during the 60-day episode. If the LUPA payment is less than the RAP payment made with the initial claim, the difference will be recovered on subsequent billings.

Payments for low-utilization episodes will be made on a per-visit basis using cost per-visit rates by discipline. Cost per-visit rates are published in the final rule (table 6). Following is a listing of the cost per-visit rates:

Home Health Discipline Type	HH Payment Rate
Home Health Aide Services	\$43.37
Medical Social Services	\$153.55
Occupational Therapy Services	\$105.44
Physical Therapy Services	\$104.74
Skilled Nursing Services	\$95.79
Speech Pathology Services	\$113.81

Low-utilization payments will be adjusted for wage index variances, but will not be adjusted for case-mix.

Using our example (see sample claim #2), let's assume that the HHA submitted a final bill that reflected only 2 home health visits over the 60-day episode of care (one skilled nursing and one home health aide visit). The LUPA payment would be calculated as follows:

Calculation of LUPA Payment		Skilled Nursing Visit	Home Health Aide Visit
1	Per-Visit Payment Amount	\$95.79	\$43.37
2	Labor Percentage	.77668	.77668
3	Labor Portion of Payment Rate (line 1 x line 2)	\$74.40	\$33.68
4	Wage Index	.9139	.9139
5	Wage Adjusted Labor Portion of Payment Rate (line 3 x line 4)	\$67.99	\$30.78
6	Non- Labor Portion of Payment Rate (line 1 – line 3)	\$21.39	\$9.69
7	Adjusted LUPA Payments (line 5 + line 6)	\$89.38	\$40.47
8	Total LUPA Payment	\$129.85	

The total adjusted payments for this example episode will be \$129.85. As the provider received a RAP payment of \$1,178.27, the excess payment of \$1048.42, will have to be recovered in future payments to the HHA.

NO RAP LUPA

In some LUPA situations the HHA will not submit a RAP. If it determines before submitting the RAP that the beneficiary will receive (or has received) 4 or fewer visits during an episode, the HHA may submit a Final Claim without submitting a RAP.

Partial Episode Payment**Accounts for Key Events in Patient Care**

- **Beneficiary Elected Transfer**
- **Discharge and Return to Same HHA**

Beneficiary Elected Transfer

- **Initial Episode Closed with PEP**
- **New Episode at Second HHA**

Common Ownership**Partial Episode Payments**

Partial episode payment adjustments (PEP adjustments) will be used to adjust HH PPS episode payments in some cases where a discharge has occurred. Discharges resulting in a PEP adjustment include:

- a beneficiary elected transfer,
- a discharge and return to the same HHA within the 60-day episode period, or

The PEP adjustment is based on the span of days including the start-of-care date/first billable service date through and including the last billable service date under the original plan of care before the intervening event. The PEP adjustment is calculated by using the span of days under the original plan of care, as a proportion of 60. The proportion is multiplied by the original case-mix and wage-adjusted 60-day episode payment.

Adjustment for Beneficiaries who Change HHAs

In situations where the beneficiary elects to transfer to a different HHA, the initial HH episode payment will be closed out with a PEP adjustment and a new 60-day episode period will start for the new beneficiary elected HHA.

Using our example (see sample claim #3), let's assume that the beneficiary elects to transfer to a non-related HHA. The beneficiary's last billable service from the initial HHA was on October 20, 2000. A PEP will be calculated for the initial HHA as follows:

PEP Adjustment for Initial HHA		
1	Total Adjusted Prospective Payment Rate (from above)	\$ 1,963.78
2	Span of Days of Care Provided by Initial HHA (Oct. 1, through Oct. 20, 20 days)	20
3	Span of Days as a Proportion of 60 (line 2/60)	0.333333
4	Initial HH PEP Payment (Line 1 x Line 3)	\$ 654.59

The total adjusted payments for the initial HHA will be \$654.59. As the provider received a RAP payment of \$1,178.27, the excess payment of \$523.68 will have to be recovered in future payments to the HHA.

A new 60-day episode period will begin at the beneficiary elected HHA.

This treatment will only be applied where the beneficiary elects a transfer between HHAs without common ownership. PEP adjustments will not apply if the transfer is between organizations of common ownership. The common ownership exception does not apply if the beneficiary moved out of the MSA or non-MSA during the 60-day episode before the transfer to the new HHA.

Discharge and Return to Same HHA

- **Initial Episode Closed with PEP**
- **New Episode for Re-Admission**
- **No Change in Condition**

Adjustment for Discharge and Readmission to Same HHA

A PEP adjustment will also be computed where a beneficiary is discharged and subsequently returns to the same HHA within the 60-day period. A PEP adjustment will only be recognized when a beneficiary reached the treatment goals in the original plan of care. The original plan of care must be terminated with no anticipated need for additional home health services for the balance of the 60-day period. The discharge cannot be the result of a significant change in condition.

The initial HHA episode payment will be closed out with a PEP adjustment and a new 60-day episode

period will start beginning with the date of the first billable service after re-admission to the HHA.

Using our example (see sample claim #4), let's assume that the beneficiary is discharged because treatment goals in the original plan of care were met. The beneficiary's last billable service from the initial HHA was on Nov. 10, 2000. The beneficiary is re-admitted to the HHA with the first billable services delivered on Nov. 25, 2000. A PEP will be calculated for the initial episode as follows:

PEP Adjustment for Initial Episode		
1	Total Adjusted Prospective Payment Rate (from above)	\$ 1,963.78
2	Span of Days of Care Provided by Initial HHA (Oct. 1, through Nov. 10, 41 days)	41
3	Span of Days as a Proportion of 60 (line 2/60)	0.683333
4	Initial Episode PEP Payment (Line 1 x Line 3)	\$ 1,341.92

The total adjusted payments for the initial HHA will be \$ 1,341.92. As the provider received a RAP payment of \$1,178.27, an additional final payment of \$163.65 will be made to the HHA.

A new 60-day episode period will begin at the HHA beginning on Nov. 25, 2000.

Note: The above example assumes the HHA had not already submitted the claim for the episode. If the claim had been submitted not reflecting the PEP adjustment, this claim would be automatically adjusted by the standard system and CWF to reflect the PEP adjustment, and recoupment would be made against future payments if warranted.

Significant Change in Condition

- **Multiple Part Calculation**
- **PEP Adjustments for Periods Before/After SCIC**

Adjustment for Significant Change in Condition

Another event that could trigger a change in payment level over the course of a 60-day episode of care is a significant change in condition (SCIC). A SCIC adjustment reflects a proportional payment adjustment for the time both before and after the patient experienced a significant change in condition during the episode. A SCIC adjustment occurs when a beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in treatment approach in the patient's plan of care. When the new assessment is input into HAVEN software, the Grouper module in that software will output a new HIPPS code reflecting the change in condition for payment purposes.

The SCIC adjustment could be calculated in multiple parts. The first part of the SCIC adjustment reflects the adjustment to the level of payment before the significant change in the patient's condition during the 60-day episode. The second part of the SCIC adjustment reflects the adjustment to the level of payment after the significant change in condition occurs during the 60-day episode. There is no limit on the number of SCIC adjustments that may be made in a given episode, though many such adjustments in a single 60-day span should prove rare.

Using our example (see sample claim #5), let's assume that the beneficiary experiences a significant change in condition on Oct. 20, 2000. The beneficiary's last billable service before the SCIC was on Oct. 20, 2000. The beneficiary receives the first billable service under the new plan of care on Oct. 25, 2000. The new HIPPS Code is HCHK1, with a case-mix weight of 1.1139.

The first part of the SCIC adjustment is determined by taking the span of days before the patient's significant

change in condition as a proportion of 60 multiplied by the original episode payment amount.

SCIC Adjustment – First Part		
1	Initial Episode Prospective Payment Rate (from above)	\$ 1,963.78
2	Span of Days of Care before SCIC (Oct. 1, through Oct. 20, 20 days)	20
3	Span of Days as a Proportion of 60 (line 2/60)	0.333333
4	Initial Episode SCIC Payment (Line 1 x Line 3)	\$ 654.59

The second part of the SCIC adjustment is determined by taking the span of days (first billable service date through the last billable service date) after the patient experiences the SCIC, through the balance of the 60-day episode as a proportion of 60 multiplied by the new episode payment.

Computation of Case-Mix Adjusted Prospective Payment Amount – After SCIC		
1	Case Mix index for HCHK1	1.1139
2	Standardized Prospective Payment Rate	\$ 2,115.30
3	Calculated Case-Mix Adjusted Prospective Payment Rate (line 1 x line 2)	\$ 2,356.23

Wage Index Adjustment to Case-Mix Adjusted Prospective Payment Amount – After SCIC		
1	Case Mix Adjusted Prospective Payment Rate (from above)	\$ 2,356.23
2	Labor Percentage of Prospective Payment Rate	0.77668
3	Labor Portion of Prospective Payment Rate (line 1 x line 2)	\$ 1,830.04
4	Wage Index Factor (table 4B)	.9139
5	Wage Adjusted Labor Portion of Prospective Payment Rate (line 3 x line 4)	\$ 1,672.47
6	Non-Labor Portion of Prospective Payment Rate (line 1 less line 3)	\$ 526.19
7	Total Adjusted Prospective Payment Rate (line 5 + line 6)	\$ 2,198.66

SCIC Adjustment – Second Part		
1	Initial Episode Prospective Payment Rate (from above)	\$ 2,198.66
2	Span of Days of Care before SCIC (Oct. 25, through Nov. 29, 36 days)	36
3	Span of Days as a Proportion of 60 (line 2/60)	0.600000
4	Second SCIC Payment (Line 1 x Line 3)	\$ 1,319.20

The total payments for the HHA are summarized below:

1	SCIC Adjustment First Part	\$654.59
2	SCIC Adjustment Second Part	\$1,319.20
3	Subtotal	\$1,973.79
	Less: RAP Payment	\$1,178.27
4	Additional Payment To HHA	\$795.52

CLAIMS EXAMPLES

Your Agency Name Address City, State, Zip										3 PATIENT CONTROL NO.										4 TYPE OF BILL 322																							
5 FED. TAX NO.										6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 10012000					7 COV D.		8 N-CD.		9 C-ID.		10 L-R D.		11																				
12 PATIENT NAME Doe Jane M															13 PATIENT ADDRESS 123 Main Street State College, PA 16803																												
14 BIRTH DATE 03151920		15 SEX F		16 MS		17 DATE 10012000		18 HR		19 TYPE		20 SRC 1		21 D HR		22 STA		23 MEDICAL RECORD NO.										24		25		26		27		28		29		30		31	
32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN CODE FROM THROUGH		37		38		39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		42		43		44		45		46		47		48		49									
														a 61 8050.00																													
														b																													
														c																													
														d																													
50 PAYER Medicare		51 PROVIDER NO. 167999		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56		57		58 INSURED'S NAME Doe, Jane M		59 P.REL		60 CERT.-SSN-HIC.-ID NO. 123456789A		61 GROUP NAME		62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES 100120000930200001		64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION											
67 PRIN DIAG CD 1629		68 CODE		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD		77 E-CODE		78		79 P.C.		80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID A12345 Greene, Mark													

Sample Claim #2 -Processed Final Claim (LUPA)

1		2		3 PATIENT CONTROL NO.		4 TYPE OF BILL 329	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 11292000		7 COV D.		8 N-CD.	
9 C-ID.		10 L-R D.		11			
12 PATIENT NAME Doe Jane M				13 PATIENT ADDRESS 123 Main Street State College, PA 16803			
14 BIRTH DATE 03151920		15 SEX F		16 MS		17 DATE 10012000	
18 HR		19 TYPE		20 SRC		21 D HR	
22 STA		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
30		31		32 OCCURRENCE CODE		33 OCCURRENCE DATE	
34		35		36 OCCURRENCE SPAN FROM		37	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		100		101	
102		103		104		105	
106		107		108		109	
110		111		112		113	
114		115		116		117	
118		119		120		121	
122		123		124		125	
126		127		128		129	
130		131		132		133	
134		135		136		137	
138		139		140		141	
142		143		144		145	
146		147		148		149	
150		151		152		153	
154		155		156		157	
158		159		160		161	
162		163		164		165	
166		167		168		169	
170		171		172		173	
174		175		176		177	
178		179		180		181	
182		183		184		185	
186		187		188		189	
190		191		192		193	
194		195		196		197	
198		199		200		201	
202		203		204		205	
206		207		208		209	
210		211		212		213	
214		215		216		217	
218		219		220		221	
222		223		224		225	
226		227		228		229	
230		231		232		233	
234		235		236		237	
238		239		240		241	
242		243		244		245	
246		247		248		249	
250		251		252		253	
254		255		256		257	
258		259		260		261	
262		263		264		265	
266		267		268		269	
270		271		272		273	
274		275		276		277	
278		279		280		281	
282		283		284		285	
286		287		288		289	
290		291		292		293	
294		295		296		297	
298		299		300		301	
302		303		304		305	
306		307		308		309	
310		311		312		313	
314		315		316		317	
318		319		320		321	
322		323		324		325	
326		327		328		329	
330		331		332		333	
334		335		336		337	
338		339		340		341	
342		343		344		345	
346		347		348		349	
350		351		352		353	
354		355		356		357	
358		359		360		361	
362		363		364		365	
366		367		368		369	
370		371		372		373	
374		375		376		377	
378		379		380		381	
382		383		384		385	
386		387		388		389	
390		391		392		393	
394		395		396		397	
398		399		400		401	
402		403		404		405	
406		407		408		409	
410		411		412		413	
414		415		416		417	
418		419		420		421	
422		423		424		425	
426		427		428		429	
430		431		432		433	
434		435		436		437	
438		439		440		441	
442		443		444		445	
446		447		448		449	
450		451		452		453	
454		455		456		457	
458		459		460		461	
462		463		464		465	
466		467		468		469	
470		471		472		473	
474		475		476		477	
478		479		480		481	
482		483		484		485	
486		487		488		489	
490		491		492		493	
494		495		496		497	
498		499		500		501	
502		503		504		505	
506		507		508		509	
510		511		512		513	
514		515		516		517	
518		519		520		521	
522		523		524		525	
526		527		528		529	
530		531		532		533	
534		535		536		537	
538		539		540		541	
542		543		544		545	
546		547		548		549	
550		551		552		553	
554		555		556		557	
558		559		560		561	
562		563		564		565	
566		567		568		569	
570		571		572		573	
574		575		576		577	
578		579		580		581	
582		583		584		585	
586		587		588		589	
590		591		592		593	
594		595		596		597	
598		599		600		601	
602		603		604		605	
606		607		608		609	
610		611		612		613	
614		615		616		617	
618		619		620		621	
622		623		624		625	
626		627		628		629	
630		631		632		633	
634		635		636		637	
638		639		640		641	
642		643		644		645	
646		647		648		649	
650		651		652		653	
654		655		656		657	
658		659		660		661	
662		663		664		665	
666		667		668		669	
670		671		672		673	
674		675		676		677	
678		679		680		681	
682		683		684		685	
686		687		688		689	
690		691		692		693	
694		695		696		697	
698		699		700		701	
702		703		704		705	
706		707		708		709	
710		711		712		713	
714		715		716		717	
718		719		720		721	
722		723		724		725	
726		727		728		729	
730		731		732		733	
734		735		736		737	
738		739		740		741	
742		743		744		745	
746		747		748		749	
750		751		752		753	
754		755		756		757	
758		759		760		761	
762		763		764		765	
766		767		768		769	
770		771		772		773	
774		775		776		777	
778		779		780		781	
782		783		784		785	
786		787		788		789	
790		791		792		793	
794		795		796		797	
798		799		800		801	
802		803		804		805	
806		807		808		809	
810		811		812		813	
814		815		816		817	
818		819		820		821	
822		823		824		825	
826		827		828		829	
830		831		832		833	
834		835		836		837	
838		839		840		841	
842		843		844		845	
846		847		848		849	
850		851		852		853	
854		855		856		857	
858		859		860		861	
862		863		864		865	
866		867		868		869	
870		871		872		873	
874		875		876		877	
878		879		880		881	
882		883		884		885	
886		887</					

(PEP Adjustment b/c of Beneficiary Transfer; this claim submitted by agency beneficiary is transferring from

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART :

(PEP Adjustment b/c of Beneficiary Discharge; this claim submitted by agency beneficiary is discharged from)

Your Agency Name Address City, State, Zip				3 PATIENT CONTROL NO.				4 TYPE OF BILL 329																																																																																																											
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 11102000				7 COV D.		8 N-CD.		9 C-ID.		10 L-R D.		11																																																																																																			
12 PATIENT NAME Doe Jane M												13 PATIENT ADDRESS 123 Main Street State College, PA 16803																																																																																																							
14 BIRTH DATE 03151920				15 SEX F		16 MS		17 DATE 10012000				18 HR		19 TYPE		20 SRC 1		21 D HR 01		22 STA 01				23 MEDICAL RECORD NO.				24				25		26		27		28		29		30		31																																																																							
32 OCCURRENCE CODE DATE				33 OCCURRENCE CODE DATE				34 OCCURRENCE CODE DATE				35 OCCURRENCE CODE DATE				36 OCCURRENCE SPAN CODE FROM THROUGH				37				38				39				40				41				42				43				44				45				46				47				48				49																																															
a				b				c				d				e				f				g				h				i				j				k				l				m				n				o				p				q				r				s				t				u				v				w				x				y				z															
50 PAYER Medicare				51 PROVIDER NO. 167999				52 REL INFO Y				53 AGO BEN				54 PRIOR PAYMENTS				55 EST. AMOUNT DUE				56				57				58				59				60				61				62				63				64				65				66				67				68				69				70				71				72				73				74				75				76				77				78			
58 INSURED'S NAME Doe, Jane M				59 P.REL				60 CERT.-SSN-HIC.-ID NO. 123456789A				61 GROUP NAME				62 INSURANCE GROUP NO.				63 TREATMENT AUTHORIZATION CODES 100120000930200001				64 ESC				65 EMPLOYER NAME				66 EMPLOYER LOCATION				67 PRIN DIAG CD 1629				68 CODE				69 CODE				70 CODE				71 CODE				72 CODE				73 CODE				74 CODE				75 CODE				76 ADM. DIAG. CD				77 E-CODE				78																																			
79 P.C.				80 PRINCIPAL PROCEDURE CODE DATE				81 OTHER PROCEDURE CODE DATE				82 ATTENDING PHYS. ID A12345 Greene, Mark				83 OTHER PHYS. ID				84 REMARKS				85 PROVIDER REPRESENTATIVE X Ima Clerk				86 DATE 10162000																																																																																							

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART :

Sample Claim #5 - Processed Final Claim (SCIC Adjustment)

Your Agency Name Address City, State, Zip										2 PATIENT CONTROL NO.										4 TYPE OF BILL 329																			
5 FED. TAX NO.										6 STATEMENT COVERS PERIOD FROM 10012000 THROUGH 11292000										7 COV D. 8 N-CD. 9 C-ID. 10 L-R D. 11																			
12 PATIENT NAME Doe Jane M										13 PATIENT ADDRESS 123 Main Street State College, PA 16803																													
14 BIRTH DATE 03151920										15 SEX F										16 MS 10012000																			
17 DATE 1										18 HR 1										19 TYPE 01																			
20 SRC 1										21 D HR 01										22 STA 01																			
23 MEDICAL RECORD NO.										24										25																			
26										27										28																			
29										30										31																			
32 OCCURRENCE CODE										33 OCCURRENCE DATE										34 OCCURRENCE CODE										35 OCCURRENCE DATE									
36 OCCURRENCE SPAN FROM										37										38																			
39										40										41																			
42										43										44																			
45										46										47																			
48										49										50																			
51										52										53																			
54										55										56																			
57										58										59																			
60										61										62																			
63										64										65																			
66										67										68																			
69										70										71																			
72										73										74																			
75										76										77																			
78										79										80																			
81										82										83																			
84										85										86																			
87										88										89																			
90										91										92																			
93										94										95																			
96										97										98																			
99										100										101																			
102										103										104																			
105										106										107																			
108										109										110																			
111										112										113																			
114										115										116																			
117										118										119																			
120										121										122																			
123										124										125																			
126										127										128																			
129										130										131																			
132										133										134																			
135										136										137																			
138										139										140																			
141										142										143																			
144										145										146																			
147										148										149																			
150										151										152																			
153										154										155																			
156										157										158																			
159										160										161																			
162										163										164																			
165										166										167																			
168										169										170																			
171										172										173																			
174										175										176																			
177										178										179																			
180										181										182																			
183										184										185																			
186										187										188																			
189										190										191																			
192										193										194																			
195										196										197																			
198										199										200																			
201										202										203																			
204										205										206																			
207										208										209																			
210										211										212																			
213										214										215																			
216										217										218																			
219										220										221																			
222										223										224																			
225										226										227																			
228										229										230																			
231										232										233																			
234										235										236																			
237										238										239																			
240										241										242																			
243										244										245																			
246										247										248																			
249										250										251																			
252										253										254																			
255										256										257																			
258										259										260																			
261										262										263																			
264										265										266																			
267										268										269																			
270										271										272																			
273										274										275																			
276										277										278																			
279										280										281																			
282										283										284																			
285										286										287																			
288										289										290																			
291										292										293																			
294										295										296																			
297										298										299																			
300										301										302																			
303										304										305																			
306										307										308																			
309										310										311																			
312										313										314																			
315										316										317																			
318										319										320																			
321										322										323																			
324										325										326																			
327										328										329																			
330										331										332																			
333										334										335																			
336										337										338																			
339										340										341																			
342										343										344																			
345										346										347																			
348										349										350																			
351										352										353																			
354										355										356																			
357										358										359																			
360										361										362																			
363										364										365																			
366										367										368																			
369										370										371																			
372										373										374																			
375										376										377																			
378										379										380																			
381										382										383																			
384										385										386																			
387										388										389																			
390										391										392																			
393										394										395																			
396										397										398																			
399										400										401																			
402										403										404																			
405										406										407																			
408										409										410																			
411										412										413																			
414										415										416																			
417										418										419																			
420										421										422																			
423										424										425																			
426										427										428																			
429										430										431																			
432										433										434																			
435										436										437																			
438										439										440																			
441										442										443																			
444										445										446																			
447										448										449																			
450										451										452																			
453										454										455																			
456										457										458																			
459										460										461																			
462										463										464																			
465										466										467																			
468										469										470																			
471										472										473																			
474										475										476																			
477										478										479																			
480										481										482																			
483										484										485																			
486										487										488																			
489										490										491																			
492										493										494																			
495										496										497																			
498										499										500																			
501										502										503																			
504										505										506																			
507										508										509																			
510										511										512																			
513										514										515																			
516										517										518																			
519										520										521																			
522										523										524																			
525										526										527																			
528										529										530																			
531										532										533																			
534										535										536																			
537										538										539																			
540										541										542																			
543										544										545																			
546										547										548																			
549										550										551																			
552										553										554																			
555										556										557																			
558										559										560																			
561										562										563																			
564										565										566																			
567										568										569																			
570										571										572																			
573										574										575																			
576										577										578																			
579										580										581																			
582										583										584																			
585										586										587																			
588										589										590																			
591										592										593																			
594										595										596																			
597										598										599																			
600										601										602																			
603										604										605																			
606										607										608																			
609										610										611																			
612										613										614																			
615										616										617																			
618										619										620																			
621										622										623																			
624										625										626																			
627										628										629																			
630										631										632																			
633										634										635																			
636										637										638																			
639										640										641																			
642										643										644																			
645										646										647																			
648										649										650																			
651										652										653																			
654										655										656																			
657										658										659																			
660										661										662																			
663										664										665																			
666										667										668																			
669										670										671																			
672										673										674																			
675										676										677																			
678										679										680																			
681										682										683																			
684										685										686																			
687										688										689																			
690										691										692																			
693										694										695																			
696										697										698																			
699										700										701																			
702										703										704																			
705										706										707																			
708										709										710																			
711										712										713																			
714										715										716																			
717										718										719																			
720										721										722																			
723										724										725																			
726										727										728																			
729										730										731																			
732										733										734																			
735										736										737																			
738										739										740																			
741										742										743																			
744										745										746																			
747										748										749																			
750										751										752																			
753										754										755																			
756										757										758																			
759										760										761																			
762										763										764																			
765										766										767																			
768										769										770																			
771										772										773																			
774										775										776																			
777										778										779																			
780										781										782																			
783										784										785																			
786										787										788																			
789										790										791																			
792										793										794																			
795										796																													

OUTLIER ADJUSTMENTS

Outlier Payments

- **Made in Addition to HHPPS Episode Payments**
- **Limited to 5 Percent of Total Estimated HHPPS Episode Payments**

The HH PPS Pricer will calculate outlier payments on a per-episode basis. Outlier payments are made in addition to the regular case-mix adjusted episode payments for episodes that incur unusually large costs. The final rule requires HCFA to estimate outlier payments based on 5 percent of total HHPPS episode payments during the fiscal year.

As a result, the fixed dollar loss amount and the loss-sharing proportion are chosen so that total outlier payments are estimated to be no more than 5% of estimated total payments. There is no need for a long-stay outlier payment since there is no limitation on the number of continuous episode payments in a fiscal year for a beneficiary. Outlier payments will be made for:

- Episodes whose estimated cost exceeds the computed threshold amount for the HHRG(s).

Costs will be estimated for each episode by applying standard per-visit amounts to the number of visits by discipline reported on claims.

- For episode payments that reflect a PEP adjustment or SCIC adjustment. The PEP adjustment results in a truncated episode period and a SCIC adjustment results in a total of the proportional payments under different HHRGs over a 60-day episode, but these periods could still incur unusually large costs.
- Outlier calculations are not performed for episodes paid on a LUPA basis

Outlier Payments are Made for All Episodes Where the Estimated Cost Exceed A Computed Outlier Threshold Amount

Outlier Payments are Made for All Episodes Except for LUPAs

Outlier Threshold Equals Episode Payment Plus Fixed Dollar Loss Amount

Fixed Dollar Loss Amount Determined by Applying Fixed Dollar Percentage (113 percent) to Wage Adjusted Standard PPS Amount

Outlier Payments are Calculated in the following Manner:

- 1. Compute Estimated Cost using National Per-Visit Amounts**
- 2. Compare to Sum of Per-Episode Payment Plus Outlier Threshold Amount**
- 3. Apply Loss Sharing Ratio (.80) to Wage Adjusted Difference**

The outlier threshold for each claim is defined as the 60-day episode payment for the HHRG(s) plus a fixed dollar loss amount that is the same for all case-mix groups. The fixed dollar loss amount is determined by applying a fixed dollar loss percentage (113 percent) to the wage adjusted standard average prospective payment amount of \$2,115.30. The fixed dollar loss percentage has been determined on the basis that outlier payments will be no more than 5% of estimated total HHPPS payments. The outlier threshold for the PEP adjustment is the PEP adjusted episode payment plus the fixed dollar loss. The outlier threshold for the SCIC adjustment equals the SCIC adjusted episode payment plus a fixed dollar loss.

The outlier payment is defined to be a proportion of the wage adjusted estimated costs beyond the wage-adjusted threshold. The threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and the wage-adjusted fixed dollar loss amount. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. The loss-sharing ratio is currently .80. The loss-sharing ratio has been determined on the basis that outlier payments will be no more than 5% of estimated total HHPPS payments.

Outlier payments are determined in the following manner:

- Calculate the case-mix adjusted episode payment
- Determine the fixed dollar loss amount by applying the fixed dollar percentage of 113 percent to the standard average prospective payment amount of \$2,115.30.
- The case-mix adjusted episode payment plus the fixed dollar loss amount equals the outlier threshold amount
- Calculate imputed cost for the episode based on the national average per-visit amounts. The national average per-visit amounts for outlier calculations in FY-2001 are listed below:

Home Health Discipline Type	HH Payment Rate
Home Health Aide Services	\$43.37
Medical Social Services	\$153.55
Occupational Therapy Services	\$105.44
Physical Therapy Services	\$104.74
Skilled Nursing Services	\$95.79
Speech Pathology Services	\$113.81

- If the imputed cost exceed the outlier threshold the imputed cost is wage adjusted and the outlier payment is calculated as 80 percent of the amount by which the wage-adjusted imputed costs exceed the outlier threshold. The outlier payment is added to the episode payment.

Sample Outlier Computation (Note: All Calculations are Performed Automatically by the HPPS Pricer Program)

To assist in understanding the outlier payment concept, we will work through a computation for a sample provider. Required data includes:

- HIPPS Code - HCGJ1
- Weight is 0.9949
- Visits by Discipline
 - Skilled Nursing – 55 visits
 - Home Health Aide – 40 visits
- Wage Index - .9139
- National Average Per-Visit Amounts
 - Home Health Aide – \$43.37
 - Skilled Nursing - \$95.79

Note: The national standardized per-visit amounts are multiplied by the number of visits of that discipline appearing on the provider's claim at the end of the episode.

Step 1 - Calculate Total Imputed Visit Cost

1. Skilled Nursing Visits 55 times \$95.79	\$5,268.45
2. Home Health Aide Visits 40 times \$43.37	\$1,734.80
3. Total imputed Cost (line 1 plus 2)	\$7,003.25

Step 2 - Calculate Outlier Threshold Amount

4. Calculate Case-Mix adjusted Episode Amount: Standard PPS Per-Episode Amount \$2,115.30 multiplied by HIPPS weight 0.9949 equals \$2,104.51	\$2,104.51
5. Calculate Fixed Dollar Loss Amount: Standard PPS Per-Episode Amount \$2,115.30 times Fixed Dollar Loss Percentage 1.13 equals \$2,390.29	\$2,390.29
6. Outlier Threshold Amount (line 4 plus 5)	\$4,494.80

Step 3 - Calculate Outlier Payment

7. Determine Outlier Amount: Total Imputed Cost (from Step 1) \$7,003.25 minus Outlier Threshold Amount (from Step 2) \$4,494.80 = \$2,508.45	\$2,508.45
8. Wage Adjust Labor Portion of Outlier Amount: Multiply Outlier Amount of \$2,508.45 times labor percentage .77668 = \$1,948.26 multiply times wage index .9139 = \$1,708.51	\$1,780.51
9. Determine Non-Labor Portion of Outlier Amount: Outlier Amount of \$2,508.45 minus labor portion of \$1,948.26 equals \$560.19	\$560.19
10. Wage Adjusted Outlier Amount (line 8 plus 9)	\$2,340.70
11. Outlier Payment equals \$2,340.70 multiplied by 80%	\$1,872.56

Total Payment to Provider (Episode plus Outlier Payment)

12. Wage Adjusted Payment for Episode (from wage adjustment example)	\$1,963.78
13. Outlier Payment from line 11	\$1,872.56
14. Total Payment to Provider (line 12 plus 13)	\$3,836.34

HH PPS PRICER DESIGN (AS OF 5/16/00)

Input Data File

**New Pricer will be Used
for HH PPS Services
Provided On or After
Oct. 1, 2000**

The input record layout has been included in the Appendix. The file will be 450 bytes in length.

The claims processing systems will pass the following data from the claim record to the HH Pricer program.

HHA-NPI	Provider Identifier (future claim item)
HHA-HIC	Health Insurance Claim Number
HHA-PROV-NO	Six-Digit OSCAR Provider Number
HHA-TOB	Three-Digit Type of Bill Code
HHA-SERV-FROM-DATE	From Date of Claim
HHA-SERV-THRU-DATE	Through Date of Claim
HHA-ADMIT-DATE	Admission Date of Claim
HHA-HRG-INPUT-CODE	Up to 6 Instances.* First 6 HRGs (HIPPS Codes) That Appear On the Claim

The following data will be calculated by the claims processing systems from the claim and passed to Pricer:

HHA-HRG-NO-OF-DAYS	Up to 6 instances.* The number of days of service applied to each HRG (span of days between the first service date and the last service date under each HRG)
HHA-MED-REVIEW-INDICATOR	Up to 6 instances. A Y/N indicator. An instance of this indicator will correspond with each HRG passed to Pricer. A Y indicator will be passed if the panel code field shows a HIPPS code and the line item pricing indicator on the claim shows the HIPPS code was changed in MR. A N indicator will be passed in all other cases.

	Both FISS and APASS will pass the medical review indicator to Pricer.
HHA-INIT-PYMNT-INDICATOR	<p>A one-position indicator to show the percentage payment to made on initial claims to a specific provider. This value will be set by the intermediary in field 19 (Federal PPS Blend Indicator) of the provider specific file and copied by the Standard System into the Pricer input record. Valid values for 10/2000 will be:</p> <p>0 = make normal initial payment</p> <p>1 = pay 0%.</p> <p>Additional values may be added in subsequent years of HH PPS, to allow variable rates of payment.</p>
HHA-REVENUE-DATA	<p>Always six instances, representing each of the six HH disciplines. (H-HHA-REV-CODE will show rev. codes 42x, 43x, 44x, 55x, 56x, and 57x in all cases. The revenue codes must be passed sorted in ascending order.) A count of occurrences for each revenue code will be passed as HHA-COVERED-VISITS-QTY. If no occurrences, pass zeroes.</p> <p>Both FISS and APASS will sort and pass revenue codes (and the quantities for each code) in ascending order to Pricer.</p>
HHA-PEP-INDICATOR	<p>A Y/N indicator. A Y indicator will be passed if the patient status on the claim indicates a transfer (patient status 06) or a discharge w/goals met and return to the same agency (new patient status 06). A N indicator will be passed in all other cases.</p> <p>Both FISS and APASS will pass the PEP indicator to Pricer.</p>

HHA-PEP-DAYS	<p>The total number of days in a PEP episode period, calculated from the earliest line item date of service on the claim through the latest line item date of service. In typical PEPs, this number will match the HRG-NO-OF-DAYS. But in cases of SCICs within PEPs, the counts must be distinct.</p> <p>Note: If the HHA-PEP Indicator is set to N the Pricer will default to 60 days even if the range of billable days of service is less than 60 days</p>
--------------	--

RHHs Will Establish a Medical Policy Parameter to Suspend Claims with More than 6 Lines with Revenue Code 0023 for Medical Review

- Pricer will only be able to price claims with 6 or fewer HRGs.
- RHHs will establish a Medical Policy Parameter to suspend claims with more than 6 lines with revenue code 0023 for Medical Review. A special workaround process will be developed for the rare case where the seventh change is justified.
- In the course of a future annual update, HCFA may require 15-minute increments, rather than visits, to be counted. In that case, a number calculated from the units field would replace the number of occurrences of the revenue code.

In The Future HCFA May Require 15-Minute Increments, Rather Than Visits to be Counted for Therapy Threshold Calculation

The Appendix includes a copy of the HH Pricer specifications. The specifications describe the Pricer calculations in detail.

PROVIDER SPECIFIC FILE

Fiscal Intermediaries are required to submit provider specific file data for HHAs to HCFA on a quarterly basis. Currently, Section 3850 of MIM Part 3 states the following:

**Section 3850 of the MIM
Must Be Revised to
Require Intermediaries
to Maintain Field 19 In
Addition to Other
Currently Required HHA
Provider Specific File
Elements.**

Hospice and HHA. --Create a provider specific history file using the following data elements for each hospice or HHA. Submit the current and the preceding fiscal years every 3 months. Code Y in position 49 (waiver code) if you want to maintain the record in your PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for these provider types.

Field 19 will be used to identify situations where medical review has determined that no RAPs should be paid to a specific provider. The following one-digit indicator will be used to pay or suppress RAP interim payments:

- O = make normal initial payment.
- 1 = make zero percent payment.

Note: Additional indicators may be added by HCFA to identify different levels of payment.

HH PPS REMITTANCE ADVICE INSTRUCTIONS

Program Memorandum A-00-23, dated April 2000, which contained the outpatient PPS (OPPS) instructions, also included a number of changes that apply to HH PPS.

HCFA will not make changes to the following items for HH PPS:

- Standard paper remittance advice format,
- ERA 835 version 3051.4A.01 implementation guide, or
- PC-Print.

All the statements below on home health billing apply only to type of bills 32X and 33X.

- As with OPPS, detailed service line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data will not be reported in paper remittance advice notices, or in

**HCFA Will Not Make
Changes to the
Following Items for HH
PPS:**

- Standard Paper Remittance Advice Format,
- ERA 835 Version 3051.4A.01 Implementation Guide, or
- PC-Print.

**Home Health Providers
on FISS Who Wish to
Receive Service Line
Level Data Must Upgrade
to Version 3051.4A.01 of
the 835**

- **Separate Payments
Will Continue to be
Made For DME Under
the DME Fee
Schedule**
- **Separate Payments
Will Continue to be
Made for
Osteoporosis Drug,
Flu Injection, and
PPV on 34x-Type
Bills.**

pre-3051.4A.01 versions of the 835 supported by FISS or APASS.

The standard paper remittance advice and the FISS version 3051.3A and 3030M 835 transactions will continue to report claim level summary data. Home health providers on FISS who wish to receive service line level data must upgrade to version 3051.4A.01 of the 835.

- As a general rule, the amount of the first payment for a 60-day episode will be reversed and withheld from the full payment made for the episode at the end of the 60 days.
- Payments for four or fewer visits will be paid using standard per visit rates, rather than under the HH PPS methodology.
- DME is not included in home health PPS payments and must be reported in a separate line/loop for the second bill in an episode. DME may not be included in the first bill for an episode. Separate payments will continue to be made for DME under the DME fee schedule.
- Separate payments will continue to be made for osteoporosis drug, flu injection, and PPV on 34X-type bills.

Intermediary Instructions for 835 Version 3051.4A.01
- Line Level Reporting Requirements for the First
Bill/Payment in an Episode.

1. Enter HC (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SSVC01-02. The HIPPS code is being treated as a type of level 3 HCPCS in this version.
2. Enter 0 (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount you are paying in SVC03.
3. Enter 0023 (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service.
5. If the HIPPS has been down coded or otherwise changed during adjudication, enter the billed HIPPS in 2-070-SVC06-02 with qualifier HC in 2-070-SVC06-01.
6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than 0023 is billed, report the line item date associated with that revenue code instead of the claim from date.
7. Enter group code OA (Other Adjustment), reason code 94 (processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. Report the difference as a negative amount.
8. Enter 1S (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.
9. Enter RB (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.
10. 2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode.
11. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when 4 or fewer visits) rather than on the HIPPS.
12. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial episode payments.

**Intermediary Instructions
for 835 Version
3051.4A.01 - Line Level
Reporting Requirements
for the Second
Bill/Payment in an
Episode (More than 4
Visits)**

**Intermediary Instructions for 835 Version 3051.4A.01
- Line Level Reporting Requirements for the Second
Bill/Payment in an Episode (More than 4 Visits)**

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.
2. Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.
3. The full payment for the episode can now be reported for the end of episode bill.
 - a. Repeat steps A1-11 for the service as a reprocessed bill. Report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.
 - b. In addition to the HIPPS code service loop, also enter the actual individual HCPCS for the services furnished. Include a separate loop for each service. HCPCS are not required to be billed with revenue code 270 services and must be reported in a separate SVC loop in the remittance advice.
 - c. Report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero-rate if denying the service) in step 9.
 - d. Report group code CO, reason code 97 (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCSs in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Do not report any allowed amount in 2-110.A-AMT for these lines. Do not report a payment

percentage in the loops for HCPCS included in HIPPS payment(s).

e. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME is paid, report in a separate loop(s), and enter the allowed amount for the DME in 2-110.A-AMT.

4. If Pricer determines that a cost outlier is payable for the claim, enter ZZ (outlier amount) in 2-062-AMT01 and the amount of the outlier in AMT02. NOTE: Since this is a claim level segment, this must also be reported in 835 versions 3030M and 3051.3A.

5. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

**Intermediary Instructions
for 835 Version
3051.4A.01 - Line Level
Reporting Requirements
for the Second
Bill/Payment in an
Episode (4 or fewer
Visits)**

**Intermediary Instructions for 835 Version 3051.4A.01
- Line Level Reporting Requirements for the Second
Bill/Payment in an Episode (4 or fewer Visits)**

1. Reverse the initial payment for the episode. Repeat the data from the first bill in steps 1-7 in section A, but change the group code to CR and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

Enter CW (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

2. Now that the first payment has been reversed, pay and report the claim on a per visit basis rather than on a prospective basis. Enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.
3. Report the applicable service dates and any adjustments in the DTM and CAS segments.
4. The 2-100-REF segments do not apply to per visit payments.
5. Enter B6 in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.
6. Report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.
7. Enter the appropriate appeal messages in a remark code data element in 2-1035-MOA and any appropriate line level remark codes in 2-130-LQ.
8. If insufficient funds are due the provider to satisfy the withholding created in B step 2, carry the outstanding balance forward to the next remittance advice by entering BF (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. Report the amount carried forward as a negative amount in the corresponding provider adjustment amount data element.

Cost Report Impact

- **Cost Reports Still Required**
- **No Separate Cost Reports for Periods Over 10/1/2000**
- **Additional HH PPS Payment Data**
- **Data to be Maintained in Accordance with Provider Reimbursement Manual**

COST REPORT IMPACT

Cost reports will still be required after the implementation of HH PPS. Separate cost reports cannot be filed for services before 10/1/2000 and services on or after 10/1/2000, where the HHA's fiscal year straddles 10/1/2000. HHAs will file a full 12-month cost report regardless of their specific cost reporting year. The Medicare statistics contained in the cost report will be separated for the 10/1/2000 implementation date. Medicare statistics for services before 10/1/2000, will be cost reimbursed, subject to the per-visit and per-beneficiary limitations. Medicare statistics for services on or after 10/1/2000 will be separately accumulated on the cost report.

While revised cost reports have not been issued, it is anticipated that HH PPS number of episodes and payment amounts will be reported on the cost report in the following categories:

- Full episodes without outliers
- Full episodes with outliers
- LUPA episodes
- PEP Episodes
- SCIC Episodes
- Total Episodes

In addition, statistics relating to charges and visits will be accumulated by discipline, as well as non-routine medical supply charges.

HH PPS data will be reported in the PS&R reports provided by the fiscal intermediaries.

Subsequent to the implementation of HH PPS, cost reports will continue to be filed in accordance with HCFA Publication 15-II. The information reported must conform to the requirements and principles set forth in HCFA Publication 15-I. Where a provider fails to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. (HCFA Publication 15-I, Section 2413)

OTHER HHA SERVICES

Payment under Outpatient Prospective Payment System (OPPS) for Certain Services Provided by HHAs

Certain services will be paid under OPPS for services provided in a HHA. These services relate to vaccines, splints, casts and antigens provided by Home Health Agencies to individuals not under an HHA plan of treatment, within the scope of the home health benefit.

Vaccines, antigens, splints, and casts are billed on bill type 34X using the list of HCPCS codes in the following chart.

Category	Code
Antigens	95144-95149,95165, 95170, 95180, 95199
Vaccines	90657- 90659, 90732, 90744, 90746, 90748, G0008, G0009, G0010
Splints	29105- 29131, 29505 – 29515
Casts	29000 –29085,29305,29450,29700 – 29750, 29799

Payment Under the Prospective Payment System for Outpatient Rehabilitation Services

Section 4541 of the BBA required payment under a prospective payment system for outpatient therapy services provided by HHAs to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment. Effective for claims with dates of service on or after January 1, 1999, the Medicare physician fee schedule will be used as the payment system.

PS&R REPORTS

- **All Existing PS&R Reports Will Continue to be Produced After Implementation of HH PPS.**
- **It Will be Necessary to Cut Off PS&R Reports For Services Provided On Or After Oct. 1, 2000**

All existing PS&R reports will continue to be produced after implementation of HH PPS. However, it will be necessary to cut off PS&R reports for services provided on or after Oct. 1, 2000. The cut-off will be necessary for all providers that have cost reporting periods that straddle Oct. 1, 2000. The cut-off will be required to properly settle cost reports with services subject to IPS

NEW PS&R REPORTS

Several new PS&R reports (or tables) will be added to the PS&R system. The new reports will capture data applicable to HH PPS. At this point, the new reports will be used primarily for HCFA statistical analysis and data collection. However, future changes to the cost report may require use of the reports for completion of the cost report. The following seven new reports will be added for HH PPS:

1. PS&R TOTAL EPISODES

This PS&R report's totals are a summarization of all types of episodes regardless of how they were paid (i.e., full episode, LUPA, SCIC, PEP, Outlier). The field, # of "Up-Coding" HHRG Discrepancy Episodes, is a count of the episodes where the provider's RAP indicates that one of the 40 payment codes which indicates the estimated of the number of therapies has reached the threshold for higher payment, and the final claim does not support that the therapy threshold was reached during the 60-day episode. In such a case, the claim is consequently downgraded to the less costly payment code. The field, # of All Other Adjustment Episodes, is a count of episodes depicting any and all other changes to the claim regarding payment. The field, Total # of Adjustment/Discrepancy Episodes, is a summation of the two previously mentioned discrepancy or adjustment fields. The field Total Non-Routine Medical Supplies includes both non-routine medical supplies currently reported on the cost report, as well as non-routine medical supplies currently unbundled

The following seven new reports (tables) will be added for HH PPS:

- 1. PS&R TOTAL EPISODES**
- 2. . HHRG TOTALS:**
- 3. FULL HHRG EPISODES NO OUTLIERS**
- 4. FULL HHRG LUPA EPISODES**
- 5. FULL HHRG PEP EPISODES**
- 6. FULL HHRG SCIC EPISODES**
- 7. FULL HHRG OUTLIER EPISODES**

and billed separately under Part B physician/supplier and outpatient claims.

2. HHRG TOTALS:

This PS&R report will show all of the fields listed below for all episodes (collectively) regardless of the payment type (i.e., full episode, LUPA, SCIC, PEP, Outlier).

3. *FULL HHRG EPISODES NO OUTLIERS:*

This PS&R report will show all of the fields listed below for only episodes paid the full episode payment amount. In other words, episodes paid LUPA, PEP, SCIC, or Outlier, payments are not reflected in this report.

4. *FULL HHRG LUPA EPISODES*

This PS&R report will show all of the fields listed below for only episodes paid as a LUPA episode.

5. *FULL HHRG PEP EPISODES*

This PS&R reports will show all of the fields listed below for only episodes paid as a PEP episode.

6. *FULL HHRG SCIC EPISODES:*

This PS&R report will show all of the fields listed below for only episodes paid as a SCIC episode. There may be some unique ways in which to count the number of episodes and occurrences without over counting for this type of episode.

7. *FULL HHRG OUTLIER EPISODES:*

This PS&R report shows all of the fields listed below for only episode paid an Outlier payment. This report could reflects all episodes paid as an Outlier payment regardless of how they were paid (i.e. full episode, PEP, or SCIC).

**The Field Total # Of
Outlier Episodes Will be
Reported On All Reports
Except for the Following:**

- **FULL HHRG
EPISODES NO
OUTLIERS,**
- **FULL HHRG LUPA
EPISODES, and**
- **FULL HHRG OUTLIER
EPISODES**

**The Field Total Outlier
Reimbursements Will Be
Reported On All Reports
Except For The
Following:**

- **FULL HHRG
EPISODES NO
OUTLIERS?, and**
- **FULL HHRG LUPA
EPISODES**

Following are the fields that will appear on the new reports:

Total # of Episodes
Total PPS Reimbursements
Total # of Visits
Total Charges
Total # of Aide (health aide) Visits
Total Aide (health aide) Charges
Total # of SN (skilled nursing) Visits
Total SN (skilled nursing) Charges
Total # of PT (physical therapy) Visits
Total PT (physical therapy) Charges
Total # of OT (occupational therapy) Visits
Total OT (occupational therapy) Charges
Total # of SP (speech therapy) Visits
Total SP (speech therapy) Charges
Total # of MS (medical social) Visits
Total MS (medical social) Charges
Total Non-Routine Medical Supply Charges
Of HHRG Up-Coding HHRG Discrepancy
Episodes
Of All Other Adjustment Episodes
Total # of Adjustment/Discrepancy Episodes

